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Reference Number:	738-01-DD
Title of Document:	Discharge Planning for Those Leaving ICFs/ID and Enrolling in a MR/RD DDSN Operated Home and Community-based Waiver (with the exception of the PDD Waiver)
Date of Issue:	February 1, 2008
Effective Date:	February 1, 2008
Last Review Date:	May 9, 2011
Date of Last Revision:	May 9, 2011 **(REVISED)**
Applicability:	Community ICF/ID, DDSN Regional Centers, and Service Coordination Providers

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PURPOSE:

To establish the expectations of the South Carolina Department of Disabilities and Special Needs (DDSN) regarding discharge planning for residents who will need services funded by a DDSN operated Home and Community-based MR/RD Waiver upon leaving a DDSN Regional Center or Community Intermediate Care Facility for Persons with Intellectual and Developmental Disabilities (ICF/ID).

POLICY:

DDSN is committed to supporting South Carolinians with disabilities through choice to receive needed services in the most integrated settings when it is appropriate and desired. To assure that needed services are available to newly discharged ICF/ID residents on the day of discharge and beyond, appropriate planning prior to discharge must occur.

ICF/ID residents who are preparing for discharge **must** receive Service Coordination Services (SCS). Service Coordination Services may be received for up to six (6) months prior to ICF/ID discharge. These services are intended to prepare the resident for discharge, thereby deterring the need for institutional (ICF/ID) care, by assessing needs, planning for delivery of services to meet identified needs, and monitoring the success of those services. Service Coordination Services are paramount to successful discharge from an ICF/ID.

When ICF/ID discharge is likely (i.e., within six (6) months of the move), Qualified Intellectual Disability or Developmental Disability Professionals (QID/DDPs) or designees must provide residents and their legal guardians information about Service Coordination Services (Attachment 1) and information about the Service Coordination Services providers available in the county in which they will live after discharge. Residents/legal guardians must choose which company or agency they want to provide services (for a list of providers, go to the DDSN website www.ddsn.sc.gov. , click "Consumers and Families" on the left hand side of the screen, then select #4 "Finding a Qualified Service Provider", then click on the link "Qualified Provider List" and then scroll down to the bottom of the page to select the link to search for "Qualified Providers by service and county." The choice of Service Coordination Services provider must be properly documented using the Acknowledgement of Service Coordinator/Early Interventionist Choice (Attachment 2). Once chosen, the resident/legal guardian or the resident's QID/DDP or designee must contact the Service Coordination Services provider to request services. The caller must be prepared to provide basic demographic information, information about the anticipated setting in which the person will live, the approximate ICF/ID discharge date, and supports/services likely to be needed in the anticipated setting. If the chosen Service Coordination Services provider is not willing to provide services, another provider must be chosen and the aforementioned process followed until a provider is found.

The chosen Service Coordination Services provider will assign a Service Coordinator who will provide Service Coordination Services to the ICF/ID resident. Services will be in accordance with DDSN Standards for Service Coordination and applicable DDSN policies and procedures. Service Coordination provided prior to discharge from the ICF/ID setting will be reported by the Service Coordination Service provider to DDSN using the "Invoice for Discharge Planning from ICF/ID and Enrolling in a DDSN Waiver Program" (Attachment 3). Service Coordination Service providers can report activity as often as monthly for up to six (6) consecutive months prior to their discharge date from the ICF/ID. For example, for someone discharged from an ICF/ID on June 15, an invoice may be submitted for reportable activities provided prior to discharge, during June, May, April, March, February and January. If a person did not move on the planned date of discharge, the Service Coordination provider can still report activity provided the activity provided is still within the six (6) month timeframe of the actual discharge date. Invoice forms must be sent to the Finance Department at DDSN.

ICF/ID services are funded by Medicaid. In South Carolina, DDSN operated Home and Community-Based MR/RD Waiver programs, which allow services similar to those provided in an ICF/ID to be funded by Medicaid when provided outside of an ICF/ID. Therefore, DDSN Waivers allow ICF/ID residents to move from the ICF/ID to another setting (e.g., a home of their own, a family member's home, Community Training Home, Supervised Living Program,

Community Residential Care Facility), that is not an institution (e.g., Nursing Facility, Hospital, another ICF/ID) and to receive Medicaid funding for services needed in that setting. For many ICF/ID residents, living outside of an institution would not be possible without MR/RD Waiver services. DDSN Medicaid Funded Service Options (Attachments 4a, 4b, and 4c) contain more information about the DDSN operated MR/RD Waiver programs.

In order to receive MR/RD Waiver services, one must be enrolled in the waiver. To be enrolled, one must:

- be eligible for Medicaid,
- be assessed to have needs that can be met through the provision of waiver services,
- be allocated a waiver slot,
- choose to receive services through the waiver, and
- meet ICF/ID or Nursing Facility (for HASCI only) Level of Care criteria.

For ICF/ID residents preparing for discharge, the Request for MR/RD Waiver Slot Allocation MR/RD Form (see appropriate Waiver manual) must be completed by the Service Coordinator within no less than one (1) month prior to discharge from the ICF/ID and sent to the appropriate DDSN District Office. At the same time, the Community Residential Admission/Discharge Report (Attachment 5) will need to be completed by the DSN Board/contracted service provider proposing to serve the person (i.e., the Residential Habilitation provider) and sent to the appropriate District Office Assistant Director (refer to DDSN Directive 502-01-DD: Admissions/Discharge of Individuals to/from DDSN Funded Community Residential Setting, for more specifics regarding discharges/admissions). If a person is not moving into a DDSN sponsored residential setting, the chosen Service Coordination provider would be responsible for completing the Residential Admission/Discharge Report.

When a slot is awarded and Notice of Slot Allocation is received, the Service Coordinator must secure the Freedom of Choice and Acknowledgement of Rights and Responsibilities from the appropriate party.

For MR/RD Waiver enrollment, one must be evaluated against the appropriate ICF/ID Level of Care criteria prior to, but not more than one (1) month before, enrollment in the waiver. Waiver enrollment cannot occur unless the person is determined to meet the criteria and the determination is made within the appropriate time period. Please refer to the appropriate Waiver manual for more information regarding Level of Care evaluations. To determine if someone meets the criteria, appropriate information about the person (i.e., Level of Care Packet) must be provided to the DDSN Consumer Assessment Team (CAT) for MR/RD or Community Support Waiver recipients and to the Department of Health and Human Service-Community Long Term Care (CLTC) for the Nursing Facility Level of Care for applicable HASCI Waiver recipients. The Level of Care Packet must be prepared by the Service Coordinator with assistance from the QID/DDP or designee and must include:

- A completed request for ICF/ID Level of Care (refer to the appropriate Waiver manual for the appropriate request form).

- A formal psychological evaluation(s) that includes cognitive and adaptive scores that support a diagnosis of intellectual or developmental disability, a related disability, or a traumatic brain injury with onset prior to age 22, or documentation that supports that the person has a related disability such as a report from DDSN Autism Division, or appropriate medical, genetic or adaptive assessments. If available, the person's DDSN Eligibility Letter should be included.

- A current plan including Behavior Support Plan, if applicable.

- Current information about the person's ability to complete personal care and daily living tasks, behavior/emotional functioning, and physical health status. For ICF/ID, the Code of Federal Regulations at §483.440(b) (5) (i) - [*W203*] requires that a final summary of the person's developmental, behavioral, social, health and nutritional status be developed. The QID/DDP or designee should provide this final summary to the Service Coordinator for inclusion in the Level of Care Packet.

When the Level of Care evaluation is complete for MR/RD or Community Support Waiver recipients, the Consumer Assessment Team will provide notification as appropriate. When the Level of Care evaluation is complete for HASCI recipients, the Community Long Term Care Office will provide notification as appropriate.

Once the ICF/ID resident has been assessed to have needs that can be met through the provision of waiver services, has chosen to receive services through the waiver, has been allocated a waiver slot, and has been determined to meet the appropriate ICF/ID Level of Care, he/she is ready for enrollment in the chosen MR/RD DDSN Waiver (i.e., the MR/RD, Community Support, or HASCI Waiver). Actual enrollment; however, cannot occur until the person is discharged from the ICF/ID. In most situations, the MR/RD Waiver enrollment date will be the date the resident is officially discharged from the ICF/ID.

If during the enrollment process, the ICF/ID resident decides not to pursue MR/RD Waiver enrollment, a statement must be obtained from resident/legal guardian declining Waiver services (see the appropriate Waiver manual for more information).

Once the statement for declination of Waiver services is completed, the original should be maintained in the Service Coordination Services record and a copy maintained in the ICF/ID record. A copy will also be sent to the District Waiver Coordinator. If the statement to decline Waiver services is not sent to the District Waiver Coordinator, the enrollment process would continue.

For ICFs/ID, the Code of Federal Regulations at §483.440(b)(5)(ii) - [*W205*] requires that a post-discharge plan of care be provided that will assist the person to adjust to the new living environment to which they are moving. DDSN MR/RD Waiver programs require that ***only*** the services included in the plan of care be provided. If any waiver services are to be received

immediately following discharge from the ICF/ID (e.g., residential habilitation), appropriate planning prior to discharge from the ICF/ID must occur.

The Service Coordinator, with input from the QMRP, will develop one plan that documents both the post-discharge plan that will assist the person to adjust to the new living environment and the MR/RD Waiver services to be furnished, the provider type and amount of services, frequency and duration of services to be delivered and meets both ICF/ID and MR/RD Waiver program requirements. This one plan must be in the format required by Waiver program MR/RD for use as the Plan of Care.

Once the plan is developed, service providers can be selected by the resident/legal guardian and authorized to provide services immediately following discharge/enrollment (i.e., effective date of authorization = the date of MR/RD Waiver enrollment).

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To access the following attachments, please see the agency website page "Attachments to Directives" under this directive number.

Attachment 1:	Service Coordination Services
Attachment 2:	Acknowledgement of SC/EI Choice
Attachment 3:	Invoice For Discharge Planning from ICF/ID and Enrolling in the MR/RD Waiver Program
Attachment 4a:	MR/RD Waiver Information Sheet
Attachment 4b:	CS Waiver Information Sheet
Attachment 4c:	HASCI Waiver Information Sheet
Attachment 5:	Community Residential Admission/Discharge Report